

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

FOR: HEALTH CARE FINANCING ADMINISTRATION

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

1. TRANSMITTAL NUMBER:
04-002

2. STATE
Kentucky

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE
SOCIAL SECURITY ACT (MEDICAID)

4. PROPOSED EFFECTIVE DATE
January 26, 2004

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 430.12(b)

7. FEDERAL BUDGET IMPACT:
a. FFY 2004 \$0
b. FFY 2005 \$0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Page 89

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):

Same

10. SUBJECT OF AMENDMENT:

State Governor's Review

11. GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

X OTHER, AS SPECIFIED: Review delegated
to Commissioner, Department for Medicaid
Services

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: Russ Fendley

14. TITLE: Commissioner, Department for Medicaid Services

15. DATE SUBMITTED: 2/04/04

16. RETURN TO:

Department for Medicaid Services
275 East Main Street 6W-A
Frankfort, Kentucky 40621

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
February 4, 2004

18. DATE APPROVED:
February 10, 2004

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
January 26, 2004

21. TYPED NAME:
Renard Murray

23. REMARKS:

20. SIGNATURE OF REGIONAL OFFICIAL:

22. TITLE: Associate Regional Administrator
Division of Medicaid & Children's Health

Revision: HCFA-PM-91-4 (BPD)
August 1991
State/Territory: Kentucky

OMB No. 0938-

Citation

7.4 State Governor's Review

42 CFR 430.12(b)

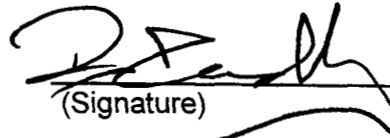
The Medicaid Agency will provide opportunity for the Office of Governor to review State plan amendments, long-range program planning projections, and other periodic reports thereon, excluding periodic statistical, budget and fiscal reports. Any comments made will be transmitted to the Centers for Medicare and Medicaid Services with such documents.

- ☒ Not Applicable. The Governor-
☒ Does not wish to review any plan material.
☐ Wishes to review only the plan materials
specified in the enclosed document.

I hereby certify that I am authorized to submit this plan on behalf of

Department for Medicaid Services

(Designated Single State Agency)

Date: January 26, 2004
(Signature)

Russ Fendley, Commissioner
Department for Medicaid Services
(Title)

TN#: 04-002
Supersedes
TN#: 01-24

Approval Date: 02/10/04Effective Date: 01/26/04